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Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me Dr. Robert Zajac. I also release Dr. Zajac to release my health information to my other physicians listed below as needed to coordinate my care.

Patient Name:_____ Date if Birth:_____

Physician/ person/ facility/ entity list below:

Name:_____

Address:_____

City: State: Zip Code:_____

Dr. Zajac may send my records to my PCP of record and others written below who are involved in my care:

Name of Provider:

Name of Provider:

Name of Provider:

The information subject to this signed release form is as follows: (please check)

( ) Any and all records

( )Complete Records ( )Medication Records

( )Care Plan ( ) Progress Notes

( )Pathology Reports ( ) Radiology Reports

( )Hospital Reports (below) ( )Operative Reports

( )History & Physical ( )Other (Please specify) _____

( )Lab Reports ( )Treatment Records

Signature: Date: